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AUTHOR Banks, Hugh C.
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ABSTRACT

This paper investigates particular aspects of the black person as client and therapist. It emphasizes the importance of heterogeneity within the black population in the understanding of the black client, the black therapist and their interaction. There are important differences between blacks due to urban vs. rural background; socioeconomic status; religious affiliation; education; etc. A stereotype of "The Black" is thus misleading. Both client and therapist must acknowledge and deal with the effects of the black stereotype in their interactions, as they can make a difference in the therapeutic outcome. It is noted that, although the black professional therapist will typically be a member of the middle or upper class, this is not necessarily true of the client. The therapist should be aware of different cultural styles among black people, especially those with whom he intends to work. Such awareness will also help the therapist strengthen his own racial identity. In the therapist-client interaction, the twin dangers of over- and under-emphasis on the importance of race are noted. The ways in which racial issues are to be resolved will depend on the particular case. (NG)

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The Black person as client and as therapist

Hugh C. Banks, New York University

The need to take account of the heterogeneous mixture of the Black culture has received insufficient recognition by those who have discussed issues pertaining to the counseling and psychotherapy* of Blacks. The most important common denominator of the Black population is its racial status -- that of being Black. Around this specific identifying characteristic there have developed environmental perceptions, values, attitudes, folklore and social expectancies which define in-group cultural differences on vertical as well as horizontal dimensions. The product of this phenomenon is a diverse and heterogeneous Black culture.

In many ways similar to non-black society, factors such as social and economic status, level of education, religious affiliation, etc., vary from one region to another. These cultural differences determine indidual values, beliefs, and attitudes and thus help explain the multiple variations of lifestyles and behavioral characteristics of American Blacks.

Whether in the great urban centers or rural communities of the nation, the acculturation of Blacks through their adoption of the dominant white culture's standards falls along an interesting continuum. On one end, there are Blacks who are anchored in the traditional folk culture of Blackness; and further along the continuum, there are Blacks who fit in a marginal culture where they are on the boundary between two different cultures and feel a part of neither. At the far extreme, there are those

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* In this paper, counseling and psychotherapy are used interchangeably; similarly, counselor and therapist.

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Blacks who have over-identified with the white culture and, in some cases, have actually passed as whites. Along this continuum, the mixtures and patterns of varying identifications and group membership have influenced childrearing practices, mores and folkways of the group, cultural life-styles, aspirational levels, achievement motivation, and even economics of the family.

All of these differences -- in regional background, lifestyles and degree of acculturation -- help us to understand better the contrast between a Black person who was born and raised on a farm in the backwoods of Mississippi and the Black who was born and raised in a large apartment complex in New York City; a Black Catholic in a small New England town as compared to a Black Methodist in Albany, Georgia; a Black Seventh Day Adventist from the Kentucky hills versus a wealthy Black Episcopalian in Chicago; or a Harvard-educated Black professor from Boston in contrast to a third grade level, poverty-stricken Black from a small town in Idaho. Given these contrasts, there still remains the critical denominator of being visibly Black and sharing a heritage of discrimination and oppression.

Yet, if we relate only to this common denominator, we forget the individual and instead formulate stereotypes about <u>the</u> Black. Members of the dominant culture persist in their use of denigrading stereotypes of Blacks. And unfortunately, many Blacks, depending on the extent of their identification with the core culture, have adopted similar stereotypes toward themselves and their fellow Blacks. It is interesting to note that

stereotypes of Blacks vary from locality to locality and, in part, reflect the distance between members of the dominant core culture and members of the Black culture. One of the unfortunate aims of stereotyping Blacks, as with other groups, is that it provides distorted descriptions of groups rather than provide clear, factual descriptions of an individual -- his particular mode of dress, speech pattern, beliefs, behavioral modes, and specific feelings and ideas. The effects of stereotypes on the therapist as well as the patient must be acknowledged and dealt with and can make the difference in the outcome of therapy (Tolson, 1972; Palomares, 1971).

The professionally trained therapist

By and large, if the Black therapist was not already a member of the middle or upperclass Black society before receiving his education and professional training, most probably he will move into the Black middle-class socio-economic strata. In many instances, this will mean that the therapist either possesses or will acquire middle or upperclass values, customs, and attitudes which along with other social forces may play determining roles in shaping his perceptions of himself and other Blacks. If the Black therapist has succumbed to white cultural standards and values and becomes a caricature of white middleclass respectability, he will bring into the therapeutic encounter his own biases and aspirations, which may differ widely from those of his patient.

While differences in therapeutic strategies, techniques and theoretical underpinnings are recognized among Black therapists, these differences

do not appear to play as important a role in the outcome of therapy with a Black patient as does the level of experience and competence of the "together" therapist. The competency of the therapist depends, among other things, on his full understanding of his own psychodynamics, specific cultural roots and self-identity (Vontress, 1970; Bell, 1971). It is necessary that he continually identify and critically evaluate his motives, comprehend the nuances of his reactions and profoundly appreciate the determinants of his judgments and decisions as they have bearing on himself and his patient. In order to authenticate himself in his role as a therapist, he should seriously learn as much as he possibly can by remaining actively involved in the educational, political and cultural way of life of different kinds of Blacks, and especially the Blacks with whom he intends to work. It is not too much to ask that the therapist, in his day to day living, keep his finger on the pulse of his culture by visiting barbershops, churches, bars, and other hangouts and meeting places of Black people. These experiences should complement his reading of published material on Blacks and enrich his discussions with them regarding the in-group cultural conditions of their regions (Smith, 1970). For example, the therapist should familiarize himself with the language patterns, slang expressions, styles of dress, hair styles, and social and interpersonal dynamics of Blacks in different cultural regions. With a full appreciation and acceptance of these differences, communication and an establishment of rapport between therapist and patient may be facilitated. More importantly, the therapist's acceptance of these factors as a part of his own broad cultural identity will reduce his prejudices toward his Black patients in general and assist him in maintaining his own emotional balance and creative lifestyle (Seward, 1972). In addition, the therapist's

acceptance of other Blacks reinforces his self-acceptance which includes his Black identity in the context of his own in-group culture.

Many Black therapists, as a result of their positive intraceptive attitudes, personal psychotherapy, and identity-building experiences with a wide range of Blacks, have "got themselves together" and "know who they are." Consequently, these therapists serve as effective therapeutic agents and role-models in their work with Black patients.

There are some Black therapists, however, who are less clear about their personal and professional identities and who bring into their therapeutic encounters personal biases and prejudices, feelings of superiority, and competitive tactics which minimize the therapeutic value of the professional interpersonal relationship. For example, they may hold themselves in low self-regard, become threatened by the psychological strength a patient might evince, lack Black cultural sophistication and not only become vulnerable to the manipulative defensive maneuvering of a dissembling patient, but also become noticeably threatened by the forceful presence of a Black patient who deviates from the therapist's standards of color, beauty, dress, demeanor, and speech. Obviously, the quality and effectiveness of the therapy in such a case is limited by the unfolding interplay of the therapist's unresolved "hangups" and the patient's problems -- all of which interacts in the context of their mutual scorn for their respective depreciative images.

The Black person as a patient

Many Black patients who seek out Black therapists do so with the expectation that the therapist has a background and set of experiences similar to his own and, consequently, that he will be most understanding of the patient, communicate with ease with him, and quickly provide magical and perhaps painless solutions to the patient's problems. The range of approaches, variety of expectations, and psychodynamics of Black patients, as you would expect, run the gamut in matter of degree and configuration. Not every Black patient is the product of a broken home, was reared under a dominant matriarchal hierarchy, or is full of self-hate, color-conflict ridden, and intensely suspicious and distrustful of all whites. The literature is full of these overgeneralizations and what may be appropriately called stereotypical notions about the Black. But do not misunderstand me: this is not to say that one or more of these conditions, and others, may not obtain for a particular Black person, and for that matter, for many Black persons. Again, the point is that you can't generalize to every Black. When the Black patient is motivated to resolve his difficulties and has the basic capacity for participating in the therapeutic encounter, given the diversity of personalities, symptoms, and problems, race is what remains as the omnipresent denominator. From this point on, the efficacy of therapy is dependent on the interaction between the Black therapist and the Black patient.

The interaction of Black therapist and Black patient

The essence of the therapeutic relationship is in the interaction between the therapist and the patient. The success of this endeavor rests mainly on the competence of the therapist -- his perceptual sensitivities,

degree of personal awareness, analytic know-how, skillful use of technique, and clear communication and understanding of the patient.

Despite the fact that the therapist may have had experiences with patients who use similar aspects of their behavior for defensive purposes or rely on similar resistance devices, it is essential that he not prejudge or anticipate the patient as if the patient had been programmed to fit generalizations about Blacks. To illustrate a point, for example: one patient may be fearful, suspicious and distrustful of the therapist based on his earlier experiences with Blacks. In another case, the patient's difficulties may have emanated from severe racial conflicts. In the former case, in the absence of the convenient race issue, the patient most probably will find some other means of resistance, and the therapist will have to recognize it and deal with it appropriately. In the latter case, if the therapist avoids dealing with the racial aspect of the problem, he may deprive the patient of satisfactorily working through his difficulties. If color-conflicts are less relevant to the basic problems, interpretations from a racial perspective may interfere by increasing the patient's resistances while maneuvering him away from the reality aspects of his problems.

In some instances similarity in race facilitates the transference, and in others it might impede its development -- particularly if the patient's racial stereotypes do not relate to the same conflicts as the transference. For example, a patient's racial stereotype of Black men was that they were lazy, "no-count," undependable, sexually promiscuous family deserters. But his father was industrious, domineering, prudish, an excellent family provider and stayed close at home with his family.

The projection of the stereotype onto the therapist delayed development of a positive transference and required the therapist to recognize the stereotypes for what they were and to deal with them appropriately as a step in expediting the course of therapy.

Familiarity with a patient's cultural background and means of communicating (such as his non-verbal behavior, vocabulary, and slang expressions) increases the level of mutual understanding between the patient and the therapist. However, the therapist incurs possible risks by employing the patient's expressions; for one thing, the patient might view the therapist as mimicking him and thus become resentful (Washington, 1968). Understanding the language and culture minimizes the necessity of the therapist repeatedly asking the patient for definitions and clarifications -- a situation which might be interpreted by the patient as an attempt by the therapist, at the patient's expense, to learn what the therapist should already know about Black culture. Overuse of slang and esoteric expressions unfamiliar to the therapist simply becomes additional "grist for the therapeutic mill" and should be dealt with in terms of the underlying motives.

When, in the course of therapy, the patient and therapist are culturally congruent, they may properly recognize and polish their cultural roots as an enhancement and enduring development of their respective Black identities.

Conclusions

There is a clear and cogent need to recognize the existence of a diverse range of individual differences and cultural backgrounds of American Blacks. Too often, perhaps as a matter of convenience, we refer to the Blacks and discuss psychodynamic and cultural factors as if all Blacks fit in the same homogeneous mold. It has been the purpose of this paper to underscore the need for the Black therapist to remain cognizant of the multiplicity of second and higher-order differences which play crucial roles in the course of therapy with Black patients.

Racial conflicts play various dynamic roles in the character and psychosocial problems of Blacks. Overattention to or omission of the significance of race in therapy may have deleterious affects on the course of therapy. Therapist attitudes, level of personal awareness, understanding of cultural determinants and professional skills are among the critical variables which will determine whether or not his therapeutic intervention is successful.

Racism in America has left its scars on the Black man, but often the scars differ from one Black person to another. Racial conflicts directly or indirectly suck the psychological blood of most Black people and, at times, leave them immobilized. Where racial conflicts assume less importance, there are other psychological problems which, for example, center around physical sickness, intra-familial conflicts, inter-sibling conflicts, and parent-child conflicts. The intricacy with which racial factors intrude into these problems is often complex and difficult to analyze. It requires skill and guts on the part of the therapist to hang in there and remain

perceptively sensitive and appreciative of the nuances which command not only understanding, but also appropriate and accurate interpersonal responses.

It has not been the intent of this paper to suggest that interracial therapy may not be successful, or that a non-black therapist is not confronted with patient problems which overlap those of a Black therapist with Black patients (Schachter and Butts, 1968). On the contrary, we know that where I have used the term Black, we may substitute a person's religion, ethnicity, gender, nationality, or age (Seward, 1972). Furthermore, we are cognizant of the fact that some Blacks are mobile and move from region to region and thereby, through acculturation mechanisms, often blur the distinctions between in-group Black cultures. We can appreciate the fact that the civil rights movement has added a new dimension to some Blacks' acquisition of pride in their basic heritage and present culture. We also know that within the Black culture, complexion hierarchies are crumbling, and "Black is beautiful." But the process is far from complete, too many of the past scars and present injustices linger in the psychology of the individual. In view of this, I believe that similarity in race (where therapist and patient are restored to their cultural roots and share the Black Experience) can be a facilitator in achieving desired therapeutic goals.

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